

## BERYLLIUM DISEASE PREVENTION PROGRAM OCCUPATIONAL EXPOSURE HISTORY QUESTIONNAIRE

Please select the best answer for each question. Please use a pen to fill out the questionnaire. Write your answers clearly.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Job Title: \_\_\_\_\_ Supervisor: \_\_\_\_\_ Telephone Extension: \_\_\_\_\_

LLNL Employee #: \_\_\_\_\_ L-Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
month/day/year

Home Address: \_\_\_\_\_ Sex: Male ☐ Female ☐

Race-Ethnic Group: White ☐ Black ☐ American Indian ☐ Hispanic ☐ Asian ☐ Other ☐

**These questions apply to your occupational (job) history. Please answer each question as best you can.**  
**NOTE: "Beryllium" means beryllium metal, beryllium containing alloy, beryllium ceramic or any beryllium compound. "Exposed" means exposure to airborne dust or particles.**

1) Please list the time period (month & year) that you started work at LLNL:

Began: month \_\_\_\_\_ year \_\_\_\_\_

2) Please list the job(s) you held, the approximate dates that you worked in this capacity, and the building(s) you worked in for each of these jobs while employed at LLNL. Note if beryllium is or was present in the workplace. Start with most recent and please use another piece of paper if necessary.

Functional Job Title	Date	Bldg/Room	Supervisor	Beryllium Present in Workplace?		
				Yes	No	Unk.
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3a) While at LLNL did you ever work with beryllium? Yes ☐ No ☐

3b) Are you currently working with beryllium? Yes ☐ No ☐

3c) Did you ever work in a building where others, but not you, worked with beryllium? Yes ☐ No ☐

3d) Did you work with beryllium in a chemical laboratory? Yes ☐ No ☐

4) If you answered yes to the beryllium exposure question (3 a, b, c or d), please describe in detail in what way(s) you feel you may have been exposed to beryllium? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5) Other than at LLNL have you ever worked with beryllium? Yes ☐ No ☐

If yes, where (name and location of company)? \_\_\_\_\_

6) Did you ever work: (General Pulmonary Background Questions, please check the correct answer and fill in years job started and ended)

In a mine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	year started _____	year ended _____
In a quarry?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	year started _____	year ended _____
In a foundry?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	year started _____	year ended _____

6) (continued from prior page)

In a pottery? Yes ☐ No ☐ year started \_\_\_\_\_ year ended \_\_\_\_\_  
With asbestos? Yes ☐ No ☐ year started \_\_\_\_\_ year ended \_\_\_\_\_  
In a cotton, flax or hemp mill? Yes ☐ No ☐ year started \_\_\_\_\_ year ended \_\_\_\_\_

7) Did you machine, polish, grind, or otherwise cut beryllium? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_  
Did you do this work outside of a glovebox or other enclosure? Yes ☐ No ☐

8) Did you work with powdered beryllium? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_  
Did you do this work outside of a glovebox or other enclosure? Yes ☐ No ☐

9) Did you work with hot beryllium metal (heat treating, welding, etc.)? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_  
Did you do this work outside of a glovebox or other enclosure? Yes ☐ No ☐

10) Did you work in or near a foundry when beryllium was used? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_

11) Were you involved in decontamination of beryllium-contaminated equipment or facilities? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_

12) Were you involved with work or on maintenance of beryllium plenums and/or ventilation ducts? Yes ☐ No ☐  
If yes, how many months total? \_\_\_\_\_ What year(s)? \_\_\_\_\_

13) Have you performed any of the following jobs in a building where beryllium is used (or on potentially beryllium contaminated equipment or supplies such as laundry)?

	Yes	How many months total?	What year(s)?
Administrative Support	<input type="checkbox"/>	_____	_____
Custodian	<input type="checkbox"/>	_____	_____
Electrician	<input type="checkbox"/>	_____	_____
Inspector	<input type="checkbox"/>	_____	_____
Laundry	<input type="checkbox"/>	_____	_____
Plumber	<input type="checkbox"/>	_____	_____
Security Guard	<input type="checkbox"/>	_____	_____
On Site 300 Shot Tables	<input type="checkbox"/>	_____	_____
Other: _____	<input type="checkbox"/>	_____	_____

14) Have you been in any significant beryllium exposure incidents/accidents? Yes ☐ No ☐  
If yes, please describe: \_\_\_\_\_

**Industrial Hygiene Review:** Beryllium Associated Worker? Yes ☐ No ☐  
10 CFR 850 Category: Beryllium Worker ☐ Formerly Exposed Worker ☐ Not applicable ☐  
Reviewer: \_\_\_\_\_ Date \_\_\_\_\_  
Industrial Hygienist